

Trends in Medical Practice

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For over twenty years officers of organized medicine across Canada have urged the members of the medical profession to study and prepare themselves for drastic changes that would inevitably occur in our professional relationships with the public. In spite of a great deal of work by individuals and by special committees, no radical changes have been effected nor any general agreement in policy adopted. The medical profession now finds itself faced with the problem of having important and probably permanent changes forced upon it by the Dominion and Provincial Governments of Canada.

The aim of any scheme of improved health service to the people of Canada, sponsored by the medical profession and adopted by our Government, should be twofold: the raising of the general standard of medical treatment to the public; and the raising of the status of the physician in the community. If any plan falls short of these two objectives, the sponsors are not measuring up to their responsibilities to the public, nor are they fulfilling the high trust placed in them by the profession.

Governments are being urged to extend their control over medical practice by expansion of state medicine or the adoption of methods, under the guise of "Health" Insurance, that will set definite and final restrictions on private medical practice. The main argument in support of this step is the claim that a large section of the public cannot afford the cost of modern scientific medical investigation and treatment.

To date, undue emphasis has been placed on the purely financial aspect of the problem. This, of course, must be faced ultimately, but it is definitely not the first consideration, either with the public or the doctor. In most of the schemes the public is sold the idea that expert medical and surgical service can be obtained by the employment of the present system of practice, providing all are willing to subscribe to a common fund from which will be paid the costs of medical service required. By emphasizing this aspect of the subject, we are hoodwinking the public and jeopardizing the status of the medical practitioner. The increase in the cost of medical care is not due to increase in medical and surgical fees. On the average, these are the same or even lower than twenty-five years ago. The additional cost is due to the expensive equipment necessary to make an accurate and scientific diagnosis and to the fact that these facilities are not organized and utilized in a way to reduce the cost to the patient. Furthermore, modern treatment requires more knowledge and skill, more time, more trained assistants, special equipment, and more closely supervised institutional care. The public is more critical and is demanding better and more expert attention and, in an increasing degree, this is being provided.

A great deal has been written about the advantages and disadvantages of the various types of medical services, namely: state medicine, prepaid hospital and medical services, and competitive private practice. It hardly seems necessary to state that these three types of medical service are in operation in Canada to-day and all are operating with varying degrees of success.

State Medicine

For instance, we do not need to argue about whether or not we want state medicine; we already have it and in an increasingly large measure. The question before the people of Canada is how much

state control is advisable in this country and to what extent do they want their own freedom of choice of physician determined by legislation. The term "state medicine" implies the diversion of public funds for the payment of medical services in the fields of both preventive and curative medicine. It also implies the supervision of medical practice by Governmental agencies and almost invariably it means the restriction of professional activities to a narrower field.

In Manitoba we have now approximately thirty percentage state medicine. In this field of medical service to the people of Manitoba are included all the activities of the Provincial and City Departments of Health, all the supplies that are distributed without cost, the services of the Provincial Laboratory, the hospitals for the treatment of mental diseases, the infectious fevers and isolation hospitals, to a very large extent the tuberculosis sanatoria and all the anti-tuberculosis activities; and also the Workmen's Compensation as well as the medical services of the Dominion Government under the Department of Pensions and National Health and the Department of Indian Affairs. There are several areas in the Province that come under the Municipal Doctor scheme. Free radium service and free x-ray treatment is provided for cancer patients from rural Manitoba. In the near future the control and treatment of venereal diseases will probably become the responsibility of the state. Lastly, because teaching was originally a part of the doctor's responsibility, we must include that portion of the cost of the Faculty of Medicine which is paid for by the Province. This forms a rather formidable array of public health services.

We, as a profession, should give immediate consideration to the problem of proper remuneration for highly trained medical personnel employed by Departments of Government. In Manitoba there are several glaring instances of an apparent lack of appreciation by the Government regarding what should be a just and adequate income for a well-trained medical man occupying a position of considerable responsibility and trust.

The principle of state medicine has received full recognition in the fields where contagion, violence and sanitation are involved. Freedom of action no longer includes the opportunity to spread indiscriminately infectious diseases such as tuberculosis, scarlet fever and diphtheria; nor to inflict bodily injury when mentally deranged; nor to pollute water and milk supplies because of ignorance, carelessness or neglect. **Both medicine and the law are involved here in the protection of healthy citizens. This is the principle that has been accepted by all elements of society.**

Prepaid Medical Services

The second form of medical service involves the principle of **insurance**. There are two types of prepaid medical service: first, in a compact community a medical service is provided by one or more medical men who have direct contact with the company employing the insured. This implies that the doctor has a certain measure of control and supervision over the amount of work demanded of him and his associates, and the remuneration that will be paid for such service. Because of the intimate relationship between the employer, the employed and the medical personnel, the plans have, on the whole, worked out satisfactorily.

Second: in such plans as, for example, the Fire-fighter's Medical Service in the City of Winnipeg, or the proposed Manitoba Medical Service Association plan, the doctor is asked to accept any loss that may be incurred, regardless of the amount of service demanded of him. Because of the fact that the people enjoying the Firefighter's medical service can call in any one of a large number of practitioners, the income from this particular service does not affect any one doctor sufficiently to make him vitally concerned with the success or failure of the scheme. He is not personally and intimately involved in the plan.

In most of the insurance schemes that have worked satisfactorily in the past, the employer usually contributed and accepted a certain amount of responsibility for its success. Private industry does this for its workmen but the City of Winnipeg has not been asked to do the same for its Firemen. This second form of medical service is paid for, not from the taxpayer's money, but deducted from the employee's monthly wage.

In examining and accepting this type of medical service, we should be able at this juncture to lay down the principle, based on sufficiently large experience of these plans across Canada, **that such plans will be approved only if the responsibility for their success is accepted by employer and the employed, as well as the members of the medical profession.** The medical profession should not be asked to underwrite a sickness insurance plan which is primarily adopted to assist people who do not receive adequate compensation for their work to pay for their medical treatment. The insurance principle is excellent; but why not adopt sound insurance methods? The sum total of the premiums must at least equal the cost of the anticipated services if the plan is to be satisfactory to both partners to the contract and to have any permanency. If, in any community, this is not possible then the plan should be subsidized by a contribution from the public treasury. It is unfair to attempt to apply a scheme that has been successful in a wealthy, highly industrialized community such as Detroit, Michigan, where only a small proportion of the total population is involved in the scheme, to a community such as Winnipeg and Manitoba where the main industry is agriculture, with its restricted income.

Private Practice

The third type of practice is competitive private practice, unsupported by Government funds and not necessarily protected by insurance funds. **Probably the severest criticism that can be directed against private competitive practice is that we have not, as a profession, organized ourselves in such a way as to make available to the general public diagnostic and treatment facilities, including laboratory and consultation service at a cost that is commensurate to the average income.** The underlying cause for this difficulty is that we have not been able to devise a method of practice that will eliminate a great deal of over-lapping and waste of time, which could be remedied largely by better organization, more special training within the limits of our individual practices, more trained assistants (nurse, technician and secretary), and more efficient utilization of laboratory and x-ray equipment.

In attacking the problem of supplying medical services to the people of Canada, we should recognize the fact that all three types of medical practice have a permanent place in our ultimate scheme. There should no longer be any argument that any one of these plans should completely cover the field of medical practice. Each method has already demonstrated that in certain spheres of medical work it has a definite advantage over the others. Each type of practice has shown both its strength and its weakness under a variety of circumstances. The job of organized medicine or of Governments is not to try to foist any one scheme on the public. Our job is to select the best in each, to develop it to its maximum

efficiency, and to apply the particular system or systems that will serve the individual community to the best advantage. We should not try to devise a blanket policy which would attempt to solve all the ills of our present system at one stroke.

In examining the National Health Insurance scheme that is at present being discussed in Ottawa, one is forced to the conclusion that the Government of the day is ill-advised to attempt such an all-embracing medical scheme. It is my understanding that the present scheme includes hospital accommodation, medical service—both preventive and curative—nursing service, dentistry, and pharmaceutical supplies. When one is faced with a problem of this magnitude, in the name of common sense why not tackle one phase of the problem, such as hospitalization, which requires urgent and immediate attention particularly with the tendency for civilian and military hospitals to mushroom up in all parts of the country irrespective of future requirements. Why not organize and systematize our hospital service to the people of Canada?

As a profession, we should recommend that the Government of Canada immediately establish a satisfactory policy with regard to the provision of adequate hospital facilities across the country and to accept a large measure of responsibility in mapping out suitable hospital areas in the rural parts of the country and first-aid posts in out-lying districts that do not justify, in population, the services of a hospital or doctor. Upon the solution of this problem rests the whole structure of the future medical and nursing services to the country. This implies the necessity of providing adequate transportation services by car, ambulance, train and airplane.

The efficiency and adequacy of medical services to any part in Canada depends not only on the provision of well-trained doctors but also **on hospital and laboratory facilities.** This will eventually require considerable re-organization in the method of practice and the special training of the doctor for the responsibility which he will assume in each area. Let us tackle this problem of hospitalization with vigor and courage and then, having acquired some experience and proficiency in this aspect of the problem, we should move on to tackle other phases.

We have a very excellent example of the way a Government should enter health services in the procedure adopted by our Provincial Governments. Step by step they have assumed responsibility for medical services that could not be supervised and managed by private agencies. This should be the procedure adopted in the future by any Government and not any hastily conceived blanket policy. Otherwise, we shall have utter chaos, aggravated by prejudice, misunderstanding and lack of co-operation by all parties. Both the public and the profession must be taken into consideration and into the full confidence of the planners. The public must be fully informed and convinced that the modifications in established practice are necessary in the interests of better national health. The profession must also be assured that governmental control and supervision does not carry in its wake political intrigue, interference and preference.

Whatever systems of medical care are developed in the future for the people of Canada, we, as medical men, should insist that agreement be reached and written into the laws of the country that no medical appointment will be given to any man or woman because of the active part they may have taken in a political organization. Politics and medicine do not mix. Whenever such a combination has been attempted, the standard of medicine or of medical practice has suffered either in the individual who attempts to combine an active political career with the practice of medicine or in the communities where political considerations are taken into account in the appointment of medical personnel. The practice of medicine is a full-time job. A doctor can no doubt render valuable service to the country by taking an active

part in politics or on occasion becoming a candidate for Parliament but such political activities in no way prepare him for a position requiring special training in any field of medicine.

Individuals who now hold positions of responsibility and authority and others who are in positions to influence public opinion and who feel that the Government of Canada should assume more responsibility and provide increased health services to the people of Canada, would do well to realize that efficient and expert medical and surgical services can not be provided for the people of Canada by the adoption of a slogan such as Health Insurance, or by simply creating a fund which will in part or whole pay for the medical services demanded by the public.

Reorganization of Medical Training and Practice

Adequate consideration should be given to the two forces that will effect any new system more than anything else combined, namely, the **continued education** of the doctor and the **better organization** of his work.

Any plan of improved medical care for the people of Canada must give earnest study to the problem of better preparation of the doctor for the particular type of service he is expected to render in his community, including both pre and post-graduate instruction. The deficiencies in our present system can only be corrected by more universal opportunity and facilities for continuation studies, and through better organization of the talent now available. This implies an effort to raise not only the standard of practice of medicine but also the status of the average physician. The public has a right to demand the highest type of medical service. To obtain this the energy of its medical personnel should be employed at a point of maximum efficiency.

Every doctor who is taking his profession seriously, and who has at considerable expense spent seven or eight years in the most strenuous pursuit of knowledge to prepare himself for his life's work, is entitled to look forward to thirty-five years of active professional work. During these years provision should be made for regular visits to medical centres where he will have the opportunity to take special intensive courses. A medical man who holds a license to practice should show evidence at stated intervals that, by reason of his continued interest and study, he is entitled to retain his license. Furthermore, we have reached the stage in the development of medical knowledge when no man should be given "carte blanche" to practice in any or every field of medicine irrespective of his special aptitude or training.

Again, if the standard of medical treatment and the status of the physician are to be raised, adequate provision must be made for nursing, laboratory and secretarial assistance, to the end that the doctor can utilize the maximum of his time to the medical care of his patients. Keeping adequate records and filling out endless forms will inevitably be expected of the doctor in the future no matter what system is devised. The doctor in a small community as well as the one in the city is entitled to the assistance required to carry out the many tasks expected of him by the Provincial Department of Health and by the public.

Education and Research

The doctor who graduates from a Canadian University has received fairly adequate training. On entering the practise of medicine he finds that he has not ready access to the laboratory and x-ray facilities or consultation service so necessary to the detection and treatment of many serious diseases. Furthermore, he finds it difficult to keep abreast with the progress of medicine because of lack of facilities and lack of opportunities to visit medical centres.

To date the efforts of the medical schools to provide adequate post-graduate instruction for the doctors of Canada are extremely limited in scope and continuity of effort. This is not due to any lack of interest on the part of the teaching staff or a

willingness on their part to sacrifice time and leisure to assist in such post-graduate activities. Lack of clinical facilities and lack of funds are in part responsible.

At least twenty-five percent of time and effort of our teachers should in the future be devoted to the continuation studies. Arrangement could probably be made to send our final year students out into rural communities to be apprenticed for a time to practising physicians. The students would benefit by practical experience under this arrangement. The practising physician would not only come in contact with young, inquiring minds, which is in itself stimulating to all teachers, but would have the necessary relief to give him an opportunity to visit medical centres for courses of study. I would suggest that men of outstanding ability and sound judgment practising in rural Manitoba, who show special interest in students sent to them under such an arrangement, might be given the position of Honorary Lecturer on our Faculty. What a great opportunity there is in broadening the sphere of influence and improving the standard of practice by such an arrangement.

The teachers should have available clinical cases in sufficient numbers to provide variety and these need not necessarily be indigent or charity cases as in the past. With improved economic conditions and with increased numbers arranging the prepaid hospitalization at nine dollars a year for one and twelve dollars or slightly more for the family, we cannot expect to maintain our clinical teaching services on the number of charity patients that will present themselves to the hospital. The profession at large, as well as the authorities, should realize the vital necessity of maintaining teaching services on a high level of efficiency and excellence.

At the present time there is a conflict, amounting in certain instances to actual antagonism, between members of the teaching faculties and members of the profession who do not enjoy the privileges and advantages that such appointments carry with them. The fact that both are engaged in competitive private practice in the same field must, in part at least, explain this difficulty.

As far as I am aware, no specific recommendation has come from organized medicine or from the associations of medical colleges regarding the measures that should be adopted to assure adequate clinical material in our teaching services. After considerable thought on the subject, I am unable to suggest a satisfactory solution to this difficult question. Upon its solution depends the future standard of graduate medical training. To a large extent, the method of procuring patients for our teaching wards depends upon the modifications that may take place in our method of practice. However, the problem is there and some individual or group of individuals in our profession must supply the answer. It deserves every doctor's serious consideration.

The whole problem of clinical teaching eventually revolves around a plan to provide modern and expert laboratory, x-ray and consultation services to the man in practice, including the specialist. There is implied in this arrangement a distinction which is hard to maintain between the consultant as such and the specialist. I visualize the consultants in medicine and surgery in the future as men who have distinguished themselves in their special fields and who are willing to forego the advantages of private practise and assume the combined responsibility of professorship, take charge of the active treatment on the teaching wards and to accept appointments on official boards and tribunals which will supervise the implementation of policies which have been adopted by the profession and the Government with regard to health services to the public. They will hold positions of responsibility and trust in the community equal to that of a supreme court judge. Definitely, they should never have taken an active part in the political activities of the party that

happens to be in power to bring about their election.

Education of the doctor and education of the public must proceed simultaneously. The raising of the standard of health in this country carries with it the responsibility of raising the standard of education and the status of the teacher. The responsibility of the individual to himself and the community with regard to the problem of physical fitness, intelligent co-operation with the various agencies interested in improved public health and the earlier detection of disease, depends on two things: namely, greater dissemination of information regarding health and disease and the preventive and curative methods available; and the ability of the general public to benefit by such an educational programme.

In view of the importance of proper nutrition to the normal development of the child and the maintenance of health in the adult, the Government of Canada should be urged to continue the nutritional laboratories that have been set up and, if necessary, to increase their number after the war. From such centres will come a better understanding of the nutritional requirements of the people of Canada. They will act as educational and information centres for this aspect of the national health programme. It cannot be emphasized too strongly to the federal authorities that we are now only on the threshold of our knowledge of the important relationship between normal health and the protective and nutritional value of foods—a great project for research and education.

The Government of Canada should be impressed with the absolute necessity of setting aside adequate funds to support medical research. In the past, fifty to seventy-five thousand dollars a year have been set aside for peace-time medical research. The debt that the people of Canada owe to the efforts of the late Sir Frederick Banting or to Collip and Best and their associates, is alone worth more in a year than such a sum. This sum is small recompense for the benefits that come to the people of Canada, not to mention the honour and prestige that has come to Canadian science. All progress in the prevention and control of disease is based primarily on research. Research projects should be encouraged and the research worker supported liberally. On the basis of our present national income, one to two million dollars a year could be profitably spent by the Dominion Government across Canada on medical research including the training of research workers and the provision of adequate equipment.

Special Training

The modern trend of medical practise is toward specialization. That is as it should be. This must be obvious to any doctor or layman who fully realizes the tremendous progress that has been made in our knowledge of disease during the last fifty years, and who appreciates the great complexity of our diagnostic and therapeutic facilities. The public is being trained to seek expert medical service and is entitled to the best service that we, as individual doctors or as a profession, can provide. Admittedly, there is a limit to which specialization in medicine should go. But, in view of the character and magnitude of the task that faces the medical profession, there is little danger of over-specialization in Canada for some time to come providing the work of the various specialists is properly co-ordinated.

It is our duty to develop plans by which increasing numbers of Canadian citizens will have access to improved facilities for medical care. This will mean some radical changes both in our method of training medical personnel and in our relationship with the public. This statement should not be interpreted as advocating complete abandonment of all the excellent and desirable practices that have been evolved in the past. It does, however, suggest an adjustment which may seem difficult for some of us but the change is absolutely inevitable.

It is my conviction that the public does not demand **cheap** but rather **expert** medical service. Nor does the public wish to force upon the medical profession a system which will curtail its privileges or rights as individuals even though it expects doctors to practice within certain prescribed limits, depending upon their special qualifications and training.

The profession should recognize and adopt officially the principle that every doctor should be specially trained to carry out the particular job that is expected of him in the community.

Group Practice

In discussing trends in medical practice one should include some observations on the development of group practice. Co-operative medical practice will become more general. Medical men who have served with the armed forces and who have worked in teams and in military hospitals will wish to continue to enjoy the advantages of easy and freer consultations in private practice. Two types of groups will be established.

One group will consist largely of general practitioners who pool their diagnostic equipment and relieve one another in their practice during periods of vacation and illness. Attached to such a group there should be a man specially trained in internal medicine and also an eye, ear, nose and throat specialist. A man specially qualified in x-ray and laboratory methods of diagnosis would almost certainly find an important place in such a group.

The second type of group practice to develop will be an organization in which all the departments of medicine are represented. The head of each department will be a specialist. Space does not permit a fuller discussion of group practice.

Summary

The success of any scheme that will assure the public of a high standard of proficiency in the prevention, diagnosis and treatment of disease and will give the physician the place in the community which his special training and serious responsibility deserves, demands considerable overhauling of our medical system. This should include internship with proper remuneration and more post-graduate facilities made possible, in part, by extending the training of the young doctor to include a term of apprenticeship in the field under the supervision of a general practitioner as well as the specialist in the hospital. It is my belief that the Medical Faculty of every University in this country will have to re-organize its programme so as to broaden its field of influence by more regular contact with every graduate in medicine. There must be better utilization of the clinical and laboratory facilities now available. Consideration must be given to the privileges that are granted by a license to practise. This might well be reconsidered every five years and special recognition given to the men who have rendered distinctive service to the community or who have qualified themselves as specialists by intensive post-graduate study and research.

These, then, are some of the problems requiring clear thinking and foresight on the part of the leaders of our profession and not whether we can with our present set-up render satisfactory service at so much per patient. Training to meet the special needs of our day and efficient organization of our professional work will solve the problem of cost of medical service to the public because in this way lies the means of reducing costs.

At this stage we should be in a position to map out the problem, to lay down certain definite guiding and established principles, and to attack it systematically and thoroughly, step by step, as our knowledge and experience increases. Let us confess that we do not know the ultimate solution of the problem and, therefore, any all-embracing and complete plan is not only premature but dangerous.

Reflections on Medical Practice

By Charles Hunter, M.D.

Eight years ago I wrote a paper for the Manitoba Medical Association Review on "Common Failures of Diagnosis in Medical Practice", and it may be profitable now to review the same subject from the Internist's standpoint.

With the present tendency to seek short-cuts in diagnosis from laboratory and x-ray examinations, it is not out of place to emphasize the cardinal value of the old virtues—a careful history and a careful physical examination, undertaken intelligently and thoughtfully considered. The bedrock of diagnosis rests now, as in the past, on these old-fashioned methods.

The patient comes to us because he feels something amiss—he has certain complaints and no amount of x-ray reports or laboratory examinations can absolve us from the necessity to spend time and care in eliciting the onset and progress of these symptoms. It may be that the family history or the patient's previous illnesses will furnish a clue. In some families, there is a marked tendency to cardiovascular disease, be it high blood pressure, angina pectoris, or apoplexy; in others, migraine and nervous instability in various forms; in still others, tuberculosis, pernicious anaemia, diabetes or goitre may offer a clue.

It takes some time to obtain a decent history, yet we must let the patient tell it in his own way, keeping him, of course, to the point but avoiding leading questions. As one gets older, one realizes more and more the importance of history-taking, duly recorded in writing at the time. Often the physical examination, be it ever so careful, reveals nothing amiss, yet the history may unmistakably suggest the correct diagnosis.

Angina pectoris is an obvious example of this truth—a middle-aged man begins gradually to suffer, on walking especially after a meal, from a distress, sometimes cramp- or pressure-like, sometimes sharper in character, across the sternum; this is relieved by slowing up or standing still and is aggravated by walking against a head wind or up a hill or in cold weather. Though physical examination be negative as it often is, though x-ray and cardiogram be inconclusive, such distress across the sternum on exercise, relieved by standing is strong presumptive evidence of angina pectoris, yet too often nowadays, physicians ignore the warning because the special examinations do not bear out the diagnosis.

So, too, coronary occlusion is missed because, though the history may be typical enough, the cardiogram is normal.

Peptic ulcer, gall bladder colic, renal calculus, beginning stenosis of the large bowel, migraine, even increased intracranial pressure do so often betray their presence through a good history, though ordinary physical examination may be quite negative.

In a middle-aged individual, increasing weakness and little loss of weight, with an early history of sore tongue and later, of numbness of the extremities, should warn one of the likelihood of pernicious anaemia.

Too often, hyperthyroidism is overlooked because the thyroid may be only slightly enlarged; yet loss of weight in spite of a good appetite, general weakness felt especially on climbing stairs or boarding street cars, nervousness and unusual discomfort from heat, point to hyperthyroidism.

Myxoedema, on the other hand, is suggested by intolerance to cold with a mental and physical slowing up of the body generally.

In middle life, the onset of dyspepsia with increasing weakness and perhaps loss of weight, should arouse suspicion of cancer of the stomach while a history of recent constipation, associated with recurring colicky abdominal pains should suggest cancer of the colon.

Remember how an almost forgotten attack of severe epigastric pain, followed by jaundice, may clear up the diagnosis of an obscure dyspepsia, while a nasty fall on the buttocks, passed off as comparatively trivial at the time, may years later suggest a crushing fracture of the spine; here the x-ray picture will readily explain the obscure backache and localized neuralgic pains.

The history of asthma or hay fever should point to allergy as possibly the correct explanation of a puzzling dyspepsia.

It gives one considerable satisfaction to try from the history alone to make a tentative diagnosis; one passes in mental review the various possibilities arising from the history; in detective fashion, some explanations are dropped and others followed up; the subsequent physical examination will often settle the claims of the rival interpretations.

Not the least of the many attractions of our profession is the review of our own histories when private patients revisit us after a long absence—humiliating no doubt in many cases to realize how far away we were from the truth, but salutary! I cannot over-emphasize the value to the general practitioner as well as to the specialist, of a careful **written** history.

It is worthwhile to routinely enquire what operations the patient has had and their exact nature: e.g. To a woman with neuralgic pains in the back, the amputation of her breast years ago may seem of no significance.

During the history taking, we more or less unconsciously size up our patient but should supplement this by a deliberate and conscious survey. The highly-strung individual with voluble and often disconnected complaints puts one on guard against accepting too readily an organic explanation of the many troubles, without substantial corroboration, while the placid, easy-going or obviously well-balanced individual with specific and often localized complaints must be rigorously examined before being given a clean bill of health. The long, narrow-chested individual has so generally sagging of the abdominal viscera and all too often is uneasily aware of his digestive organs.

We should examine in every case with special care the part of the body to which patients refer their symptoms. Not only may a local explanation be found but, in any case, the patient's confidence is better secured when he realizes that his physician is attentively considering the site of his complaints.

In our general survey, we often get a hint which we may miss in the detailed examination. E.G.: Slightly prominent eyes with nervous, jerky restlessness will lead us to examine more closely the neck for possible slight thyroid enlargement. In its early stages, paralysis agitans is often missed just because of lack of a general conscious survey—the immobile face, the seldom winking eyes, the absence on one side of the usual swing of the arm, the deliberate movements should put us wise, if we but look. In a younger person, such signs suggest a preceding encephalitis. Slight jaundice is sometimes overlooked because the colour of the conjunctivae was not noted;

the lemon tint of pernicious anaemia, the pallor of secondary anaemia, the stark white pallor of recent haemorrhage, the grayer tint of malignant disease are often eloquent of the underlying diagnosis. We far too often discount obesity and the tremendous importance it plays in disease; a glance at the Insurance Companies' mortality figures for obesity should remind us of its direct effect on the life-span of the individual. But still more important is its influence in disease; degenerative troubles of the cardiovascular system are more common in the obese; most diabetics are originally overweight; gall stones, diverticulitis and hernia in the digestive system, bronchitis and emphysema in the respiratory system, osteoarthritis of the spine, hips and knees, flat feet and myalgia in the orthopaedic line, are all admittedly commoner in overweight people. The surgeon knows well the greater mortality and the higher incidence of unforeseen complications in his operative cases who are overweight. A campaign by the medical profession against obesity is long overdue.

Turning from the general survey of our patient, we pass to the detailed examination. In but few medical diseases, is it safe to pass at once to an examination confined to the region of the body where the patient's complaints are localized. Strip the patient and make a routine examination in which all the systems are deliberately considered; the history just obtained naturally leads to special care in the examination of any organ under suspicion. I think in routine examination certain errors are frequently made.

1. Too often the thyroid is not deliberately examined. It is wise, in this goitrous district, in passing from inspection of the mouth and neck downwards, to palpate the thyroid in every case and let one's thoughts dwell for a moment on the history, from the thyroid standpoint.

2. The mere rise of systolic blood pressure even to a considerable height, say 160-180 mm. does not justify the diagnosis of essential hyper-tension if the diastolic pressure be below 90 or possibly, at times, even below 100. On the diastolic pressure mainly depends the strain on the cardiovascular system and only when it is raised should one speak of high blood pressure. A high systolic combined with a low diastolic blood pressure suggests exophthalmic goitre, aortic regurgitation, arteriosclerosis of the aorta and sometimes merely a passing nervousness.

3. The spleen should not be forgotten—a palpable spleen may point to a blood dyscrasia or to an infective endocarditis developing insidiously on old valvular disease. The significance of an enlarged spleen is hardly appreciated; should doubt exist as to the splenic origin of a left-sided abdominal tumour, the lowering of the splenic flexure seen by x-ray after a barium enema should settle the point.

4. Rectal examination is too often neglected; the patient's diagnosis of haemorrhoids is accepted without question when a finger in the rectum may reveal an obvious carcinoma; secondary deposits in Douglas' pouch may be discovered, while in elderly men the prostate should never be forgotten.

5. Microscopic examination of the urine should be made at least in all obscure cases. When there is any doubt about renal insufficiency, a good specific gravity (i.e. over 1020) is very reassuring, while a persistently low specific gravity, in spite of restriction of fluids for twenty-four hours, should warn one of possible advanced renal disease.

6. The spine is often forgotten. If freely movable in all directions, an x-ray will rarely show anything of importance, while impairment of mobility is often a positive indication for an x-ray. Poker spine with

very little movement throughout, is apt to be overlooked, as I have personally noted on several occasions. Obscure, localized abdominal pain, waking the patient at night and relieved by moving about, may be due to decalcification of the vertebrae in elderly people or may follow injuries of the spine sustained in the distant past. It seems in these cases that with the complete relaxation of sleep, nerves are pressed on; the resulting neuralgic pain is relieved by the voluntary bracing of muscles in the erect position. In passing, one may say that a hard mattress is usually more comfortable for such sufferers.

7. The electric ophthalmoscope makes it easy to examine the fundus and its use should be more general. Certainly all cases of persistent headache must be so examined. Not only optic neuritis or choked disc, but the changes common in renal disease or in long continued hypertension are readily detected by the ophthalmoscope and may clear up the diagnosis.

8. Examination for pulsation of the arteries at the ankle joint is necessary in all obscure pains of the lower extremities. The absence of pulsation here with marked blanching of the raised foot and dusky discoloration of the dependent foot, reveals a dangerous cutting-off of the peripheral circulation as met with in Buerger's Disease or in the arteriosclerosis of diabetes or elderly persons.

9. In all abdominal cases where difficulty of diagnosis exists, the stools should be inspected and blood and pus should be tested for; longstanding anaemias of uncertain origin similarly demand examination of the stool for blood.

10. I still use the old-fashioned test breakfast of tea and toast, pumping out the stomach an hour later and doubt if the newer methods are any improvement. The very appearance of the contents recovered gives one a clue to the gastric digestion—coarse, poorly broken-up starch in gastric anacidity contrasts sharply with the thin, finely broken-up gruel with plenty of supernatant fluid, so commonly found in ulcer. The practitioner who has not at hand the means for a quantitative examination of the percentage of Hydrochloric Acid, will find Congo Paper and Toepfer's Reagent reasonably satisfactory. A careful microscopic examination of the recovered fluid will disclose the presence of pus and blood though a chemical examination for the latter may also be necessary.

Following the ordinary physical examination, one must not forget the man above the eyebrows. Even should organic disease be obviously present, much of the trouble may still be nervous in origin. Long years may pass before a mitral stenosis actually impairs the patient's efficiency but during this latent period, pain over the left breast, palpitation and faintness may often be present, engendered by the patient's knowledge of the lesion with a resulting emotional reaction. It is up to the physician to assess the part any organic disease plays in the picture and too frequently we are unduly pessimistic.

A cynic might remark how completely chronic appendicitis has dropped from our vocabulary in recent years and how our patients, sensing the professional change of heart, complain much less frequently and less insistently of right-sided abdominal pain. A similar improvement has taken place in our attitude towards innocent little "cysts of the ovary" on which our female patients used to dilate at length. It has often struck me that our saner conservatism towards the pelvic organs would have been hastened, had only female gynaecologists had a chance to retaliate by attacking the minor thickenings and varying hardness of the epididymis with an occasional sadist removing the whole works.

Nowadays, Psychosomatic Medicine is a brand new term, covering the old field of functional ner-

vous disease and the increasing interest in, and understanding of, this wide subject is one of the most encouraging features of modern medicine. In every case where the detailed physical examination fails to explain all the symptoms complained of, the physician must consider the psychological angle. The general practitioner is here in a more favorable position than the specialist for he already knows much of his patient's background. Worries and problems confronting the latter in his domestic and business relationships are often obvious or may have to be tactfully investigated. The war has brought a flood of grief and anxiety to so many homes; readjustments in business and work, due to war restrictions and labour shortage, seen not only in the office or factory but pressing quite as acutely on the women at home, create new difficulties, sometimes almost insoluble. And beyond these obvious factors, lie the bewildering and often incalculable reactions of the individual to his specific problems. For heredity and upbringing have conditioned him to react differently to apparently similar situations. So frequently, the patient knows he has problems to face and adjustments to make; he comes to the doctor, with his headache, sleeplessness, anorexia, palpitation and obscure bodily discomforts, but he does not realize that the latter are directly due to the former. He honestly believes that his indigestion or chest pain is due to "something wrong" with his stomach or heart and expects the physician to treat accordingly. In other cases, he may intellectually appreciate that his symptoms are the result of his unsatisfactory adjustment to personal problems, but these for the time being at least, seem insoluble—he cannot accept and resign himself to the inevitable or in happier fashion, fight out and win. Time alone in many cases will bring partial relief but at least the physician should appreciate the situation and should not treat the presenting symptoms as due to local causes alone.

I have a word to say in regard to special examinations:

X-ray examinations and laboratory investigations should, in my opinion be ordered only after a general examination of the patient suggests the necessity for their employment; used as short-cuts in diagnosis, these outside tests may be very misleading. It does not help a patient much to be made aware that he has a non-functioning gall bladder, should his symptoms be due to a spastic colon or to emotional reactions from some unsolved personal problem. A fluoroscopic examination of the chest is, however, inexpensive and frequently of the greatest value in doubtful cases—not only T.B. but enlarged glands, secondary metastases, bronchial carcinoma, enlargement of the heart and aorta or plunging thyroid may be apparent at a glance, corroborated, if necessary, by a plate, while a negative fluoroscopic examination is most reassuring. In obvious cases of duodenal ulcer where expense is a consideration, I frequently do not order an x-ray, but where malignancy of the stomach and especially of the colon has to be considered, a barium enema in the latter case and an x-ray of the stomach in the former, is imperative. One need not pay much attention to a non-functioning gall bladder unless the dyspeptic symptoms are insistent and cannot be controlled by medical means, while the discovery of gall stones does not automatically suggest an operation. Sir William Osler wrote a paper on the advantages (to the patient) of discovering a trace of albumin in a middle-aged man and with some truth, one might suggest that a similar attitude may sometimes be taken in regard to the discovery of gall stones. One can get a patient so threatened to conform to rules of diet and healthful measures generally and so effect a transformation in his well-being. I hasten to add that recurring attacks of colic, jaundice or fever should place the patient on the surgical side.

An intravenous pyelogram is perhaps too seldom ordered by the practitioner and, in general, the present of pus from the urinary tract demands a thorough investigation, usually by a specialist, unless it is readily cleared up by Sulfathiazole, while the origin of hematuria should in all cases be determined if possible and its significance in the early stages of malignancy of the kidney should never be forgotten.

A full blood count should probably be within the powers of the younger practitioners at least, though all doubtful cases of anaemia should, in my judgment, be checked by a well-equipped laboratory. The sedimentation rate is a simple test which, if unduly raised, removes the patient from the nervous category and demands a thorough investigation as to the possible underlying cause. Its value in T.B., in pelvic disease and in rheumatoid arthritis is, of course, established.

Basal metabolic estimations unless performed under the best conditions are, in my judgment, worse than useless; in any case, I rely much more on the general clinical picture of hyperthyroidism than I do on the basal metabolic rate and a lowered basal metabolic rate is present in many conditions besides myxoedema. It brings thyroidectomy into disrepute if invoked simply because of a raised basal metabolic rate.

The electrocardiogram is a two-edged weapon and its findings must be closely correlated with the clinical history in order to be of value to the practitioner. The diagnosis and treatment of the average cardiac case rests, as before, on the well-established methods; the cardiogram is sometimes essential where coronary thrombosis is suspected, in obscure arrhythmias and in certain cardiac symptoms developing in middle-aged and elderly people. The over-emphasis on cardiograms is partly due to their extensive use by Life Insurance Companies where, of course, they are of greater value because of the difficulty in obtaining a frank and honest history.

In all obscure cases, a Wassermann is indicated though, I should add, but rarely in my private practice have I found the test positive.

Obituary

Dr. Thomas Loughheed of Vancouver, who was visiting his son, Dr. Morley S. Loughheed, died on August 4 in the Winnipeg General Hospital. He came to Winnipeg in 1881 and for eight years taught school at Lower Fort Garry until he entered Manitoba Medical College. After graduating he practised for thirty-five years at Glenboro and Cypress River and then retired to the Pacific coast.

Our sympathy is extended to Dr. Morley Loughheed on the death of his father.

Manitoba Health Officers' Association Third Annual Meeting

St. Regis Hotel

SEPTEMBER 12th, 1944

Morning

12.00 Registration.

12.30 Luncheon.

All Health Officers will be guests of the Minister of Health.

Address by the Hon. Ivan Schultz.

Afternoon

2.00 Anterior Poliomyelitis. After Treatment. Dr. C. E. Mather.

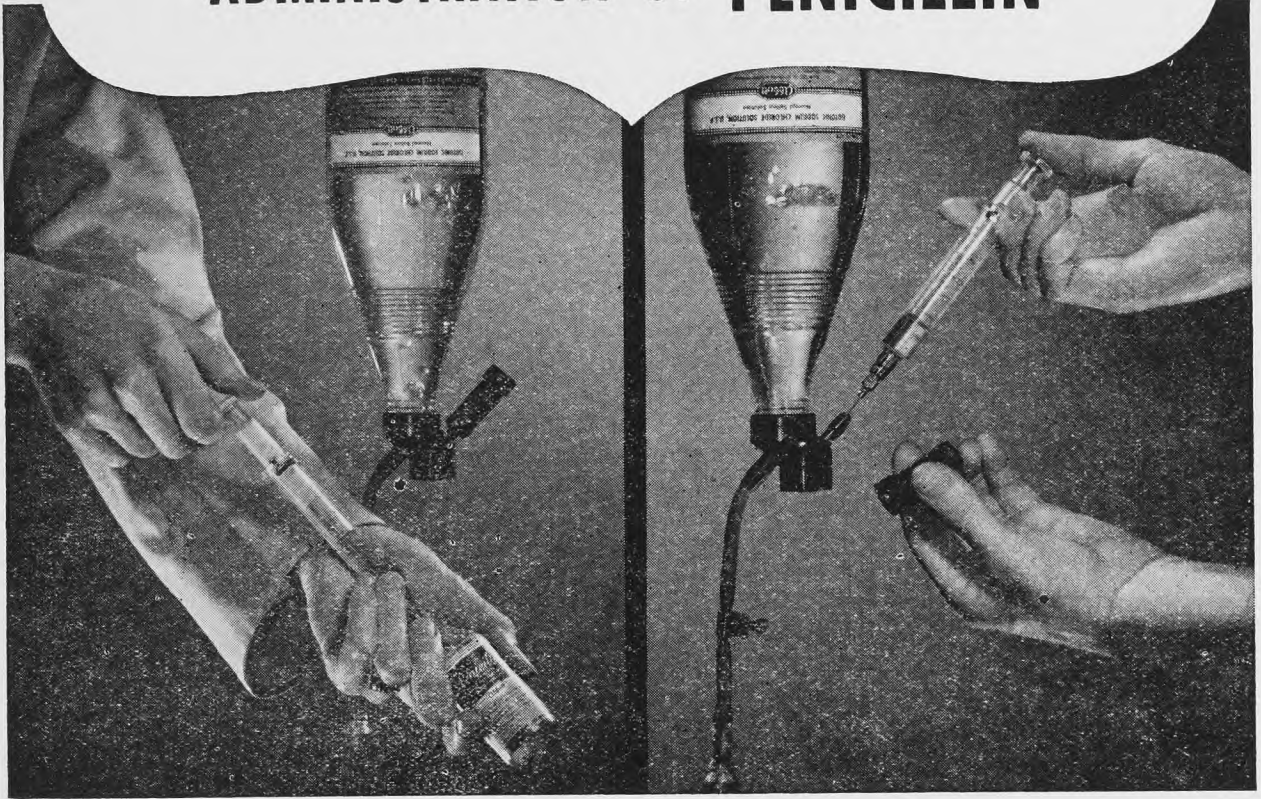
2.40 The Acceptance by the Municipalities of "The Minimum Standard of Health Service for the Part-time Medical Health Officer." Dr. Donovan.

3.30 Annual Meeting and Election of Officers. Presidential Address. Dr. Morley Loughheed.

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ADMINISTRATION OF PENICILLIN



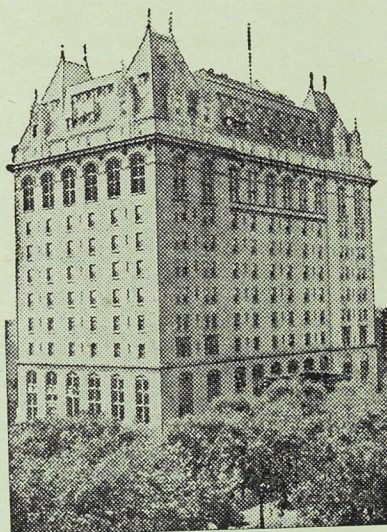
If you are now employing Abbott Venoclysis Equipment and Abbott Intravenous Solutions in bulk containers, you perhaps already know how easily the Abbott Equipment can be adapted for the administration of Penicillin by the intravenous drip method. The specified dose of penicillin is conveniently added to the intravenous solution vehicle by removing the air filter and injecting through the air filter nipple of the dispensing cap. The air filter is then replaced . . . and nothing more is required! Air bubbles passing into the solution during administration assure uniform, thorough mixing of the penicillin with the solution. • If you are not using the Abbott Venoclysis Equipment in your hospital may we suggest that you ask your Abbott professional service representative to demonstrate the Abbott technique at your convenience. We believe that you will be impressed with the safety, simplicity and adaptability of the Abbott Equipment. ABBOTT LABORATORIES, LIMITED. Montreal.

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THE
FORT GARRY
HOTEL

Manitoba Medical Association

(Canadian Medical Association, Manitoba Division)

Annual Meeting Programme

Tuesday, September 12th

- | | |
|---|---|
| 6.30 President's Dinner to the Retiring Executive, Drawing Room, Mezzanine Floor, Fort Garry Hotel. | 8.00 Executive Meeting at the Fort Garry Hotel. |
|---|---|

Wednesday, September 13th

Morning

- 8.30 Registration. Seventh Floor.
- 9.30 Symposium on Penicillin.
 "Medical Uses of Penicillin."
 Sq/Ldr. L. G. Bell.
 "Bacteriological Aspects of Penicillin."
 Dr. T. H. Williams.
 "Surgical Aspects of Penicillin."
 Major G. H. Ryan.
- 10.30 Intermission. Visit to Interesting Commercial Exhibits.
- 10.45 "Neurogenic Bladder Due to Spinal Cord Injury."
 Major D. Swartz.

11.15 "Psychiatry in General Practice."

Dr. G. H. Stevenson.

12.15 Luncheon. Fort Garry Hotel.

Guest Speaker: Major Norman L. Elvin (or)
 Lt.-Col. C. H. A. Walton.
 Subject to be announced.

Afternoon

St. Boniface Hospital

2.00 Clinical Programme.

Under direction of Doctors E. W. Stewart,
 A. C. Abbott and A. Hollenberg.

Thursday, September 14th

Morning

- 9.00 "Health Insurance."
 Doctors H. McPhedran, M. R. MacCharles and
 T. C. Routley.
 Twenty minutes each. Discussion after each
 speaker from written questions.
- 10.45 Intermission. Inspect Interesting Commercial Exhibits.
- 11.00 Acute Diverticulitis of the Sigmoid.
 Dr. Albert Ross.
- 11.30 Differential Diagnosis of the Anaemias.
 Dr. William Magner.

12.15 Luncheon. Fort Garry Hotel.

Guest Speaker: Dr. G. H. Stevenson.
 Subject to be announced.

Afternoon

Winnipeg General Hospital

2.00 Clinical Programme.

Under direction of Dr. D. Nicholson.

Evening

- 6.30 Dinner: Annual Business Meeting and Election of Officers. Fort Garry Hotel.

Winnipeg, September 13, 14, 15

Headquarters Seventh Floor

The Fort Garry Hotel

Friday, September 15th

Morning

9.00 Infection of the Lung in relation to the Anatomy of the Bronchial Tree.

Dr. D. L. Scott.

9.30 Thyrotoxicosis.

Dr. H. McPhedran.

10.00 Management of Head Injuries.

Dr. H. F. Cameron.

10.30 Interruption of the Anterior Cerebral Fibres.

Doctors Stuart Schultz, H. S. Evans and K. J. Clark.

11.00 Intermission. Visit to Interesting Commercial Exhibits.

11.15 Poliomyelitis.

Dr. E. K. Cunningham.

11.45 Fractures of Neck of Femur.

Dr. E. Johnson.

12.15 Luncheon. Fort Garry Hotel.

Guest Speaker: Dr. J. R. Davidson.

"My line of thought on the Experimental Work I have been interested in for the past few years."

Afternoon

1.30 Annual Golf Tournament.

The Annual Golf Tournament for the Manitoba Medical Association Cup and other trophies will be well worth shooting for. The Golf Committee has arranged a good time for all.

Public Meeting---Thursday, September 14th

8.00 Public Meeting. Grace United Church

"The Medical Man's Position in the Coming National Contributory Health Insurance Scheme."

Dr. H. McPhedran.

Lt.-Col. C. H. A. Walton (or) Major Norman L. Elvin. Subject to be announced.

Dr. William Magner.

"Cancer."

Visiting Speakers

Dr. Harris McPhedran,

President, Canadian Medical Association, Toronto.

Dr. William Magner,

St. Michael's Hospital, Toronto.

Dr. G. H. Stevenson,

The Ontario Hospital, London.

Dr. Albert Ross,

Montreal.

Ladies' Programme

There will be a representative of the Ladies' Committee at the registration desk. Please leave your name, city address and telephone number. The Ladies' Committee will see that you are kept in touch with all its activities.

Fort Garry Hotel Rates

Headquarters for the Annual Meeting are at the Fort Garry Hotel. Every comfort and courtesy that modern facilities and efficient personnel can give, will be provided at reasonable rates to help make the Convention an outstanding success. Arrange for your reservations early by writing direct to the Hotel or to the Association.

Rates: Single with bath, \$3.50 up. Double with bath, \$5.00 up.

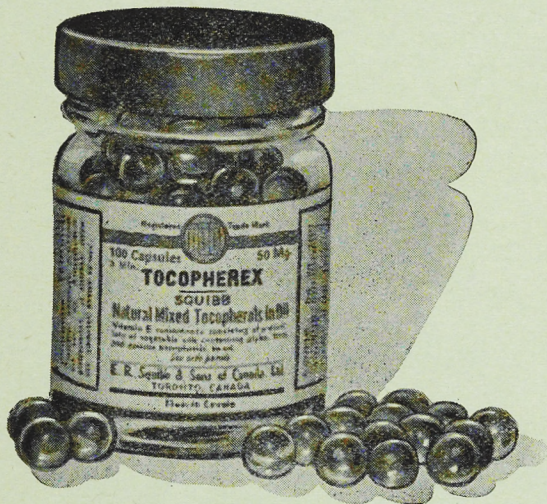
Commercial Exhibits

Nineteen Commercial Exhibitors, representing the leading Pharmaceutical, Biological, Surgical and X-Ray manufacturers, will display their products and their representatives will gladly impart detailed information that will be of an educational value.

The Coca-Cola Co. have once again generously volunteered to quench little or large thirsts of all visitors — Gratis.

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SUGGESTED FOR TREATMENT OF THREATENED OR HABITUAL ABORTION DUE TO VITAMIN E DEFICIENCY

- Each capsule contains 50 milligrams of mixed tocopherols, equivalent in vitamin E activity to 30 milligrams of a-tocopherol.

Tocopherex contains vitamin E derived from vegetable oils by molecular distillation, in a form more concentrated, more stable and more economical than wheat germ oil.

For experimental use in prevention of habitual abortion (when due to Vitamin E Deficiency): 1 to 3 capsules daily for 8½ months. In threatened abortion: 5 capsules within 24 hours, possibly continued for 1 or 2 weeks and 1 to 3 capsules daily thereafter. Tocopherex capsules are supplied in bottles of 25 and 100.

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One tablet is equivalent to two capsules.

How supplied:

Capsules—Bottles of 100 and 1,000.

Tablets —Boxes of 51 and 250.

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Editorial

The principal business of this month is, of course, the Annual Meeting of the Manitoba Medical Association which begins on Wednesday, September 13th. The speakers and their subjects are set forth in detail elsewhere. We hope, naturally, that everyone will make the necessary effort to attend. We trust, but we cannot promise, that most of the papers will find their way into these pages.

For the coming season we have laid plans which, if they mature, should assure our readers a series of good meaty Reviews, papers that will come into the business and bosoms of all our readers. J.C.H.

★ ★ ★

The Friedman Pregnancy Test

At the request of the Department of Obstetrics and Gynaecology of the University of Manitoba this test was undertaken in the Department of Biochemistry in the beginning of 1934 under my direction. It is sponsored by the Medical Research Committee of the University and is controlled by a special Committee, which at present consists of Doctors J. D. McQueen, F. G. McGuinness, R. B. Mitchell, and S. Kobrinsky, of the Department of Obstetrics and Gynaecology, and myself as Convenor.

Neglecting the very few cases done for research and teaching purposes, the number of paid tests increased steadily from 98 in 1934 to 629 in 1943, i.e., from a monthly average of 8 to a monthly average of 52. In the first two months of this year the figures were 79 and 74.

A shortage of rabbits occurred first in February, 1942, leading to a little delay in carrying out the tests. A more serious shortage occurred in October and November of that year, resulting in some delay, but the shortage was overcome by the use of rats for some proportion of the tests. Although rats were used as far as they were available during the first half of 1943, a serious shortage of rabbits occurred in May; there were marked delays in carrying out the tests, and many were cancelled.

A marked increase in the number of tests in the latter half of 1943 and the first two months of 1944, coupled with breeding difficulties in our rat colony, led to drastic steps being taken last March, since which time we have only done very urgent cases (the average number, from April to July inclusive, was 12 per month).

This has enabled us to build up a stock of rabbits which will permit a slight, but only a slight increase in the number of tests that can be done.

I cannot help feeling that the employment of this test has been considerably abused. Many

tests have been asked for, purely on sociological grounds. It has become customary to ask for the test merely to satisfy the patient and relieve or attempt to relieve her mind; delay of a few weeks in a considerable proportion of cases would have permitted a clinical diagnosis with certainty and without any danger to the patient. Too much of the time of technicians of my staff has been occupied with the routine of the test, instead of being spent in giving assistance in the research work of the Department.

The co-operation which we have received from the Profession, once the shortage of test animals became acute, suggests to me that, with continued co-operation, it will be possible to carry on the test throughout the year, without the recurring shortages, which must lead to much annoyance to members of the Profession who want the test done.

There is evidently a definite limit to the number of doe-rabbits available in the neighbourhood of Winnipeg, and there has probably been a steady drain on the breeding animals. As far as I can judge, we cannot count on more than 40 a month throughout the year, and possibly on not more than 35.

As it is extremely inconvenient to discuss each case individually with the doctor requesting the test (and indeed almost impossible with the considerable proportion of cases outside Winnipeg) we believe that we, and the Profession, should govern ourselves by the following rules.

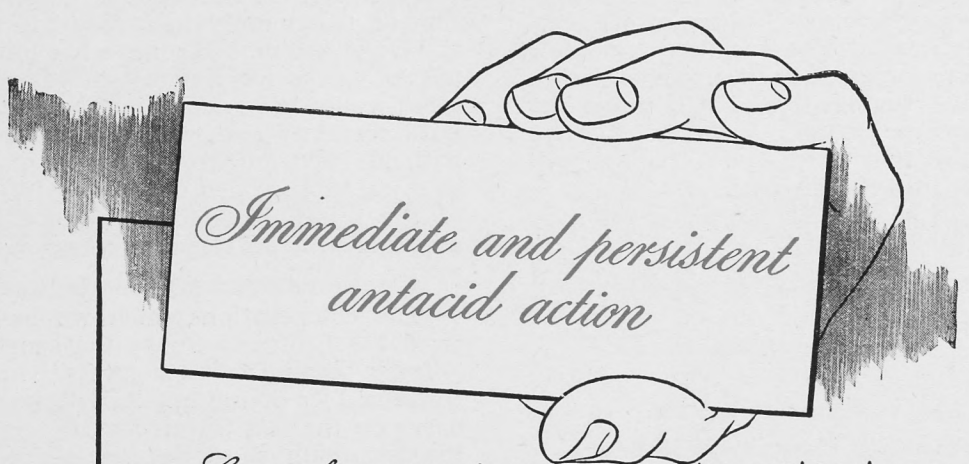
Tests should be done in the following types of case: Any case involving a possible pathological complication (e.g., tuberculosis, a heart condition, etc.); any case where (as for example it is almost essential for the patient to undertake a distant journey) it is very desirable to ascertain within the next few days the presence or absence of pregnancy; check-ups from time to time following expulsion of a hydatidiform mole.

We should not be asked to make tests on the following types of case: Cases of sociological type; cases in which there is no urgent need for the test, and in which a delay of a few weeks will permit the usual clinical diagnosis.

We urgently ask the support of the Profession in applying these rules, as we wish to be able to continue to give this service. If the co-operation is not given I can foresee that before very long my Department will be forced to discontinue doing the test.

On behalf of the Committee,

A. T. Cameron.



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Winnipeg Medical Society—Notice Board

P. H. McNULTY—President

A. M. GOODWIN—Vice-Pres.

W. F. TISDALE—Secretary

E. S. JAMES—Treasurer

I think we can promise you good meetings this year. The plan is to make the session into a sort of Refresher Course with emphasis upon the daily needs of the general practitioner. After all, Winnipeg is an important teaching centre and why can't we offer the members of this Society a winter of post-graduate study? You know how doctors surge in every spring to attend the special courses put on by the Post Graduate Committee. Well, our aim is to carry such a scheme for the season; and, if you attend as a student, listening as such and, above all, questioning the speakers as such, it needs little imagination to see how much everyone can get out of every meeting.

As planned now the September meeting will be devoted to the cardio vascular system.

That is what we have planned but circumstances may change our plans. It is always possible that the Executive may decide that the M.M.A. meetings are enough for one month.

Before the scientific programme, a few minutes will be occupied in the little ceremony of conferring Life Membership on Dr. F. D. McKenty. His sponsor will be Dr. C. M. Strong. Dr. McKenty was out of town in May when his colleagues were honored. Dr. McKenty deserves much more at our hands than a mere certificate but Life Membership is the highest honor within our power to give him.

Let me reiterate our President's invitation to men in uniform. We are anxious to have every one possible attend. There need be no fear of intruding or of not being wanted. Come and get in the habit of coming! Likewise, come early, for the meetings begin on the dot of 8:15.

J.C.H.

At one of the early meetings we plan to have a paper or two on skin diseases. This is a subject about which everyone can learn something because the ignorance of the profession is nowhere deeper than in the field of dermatology. Indeed I am inclined to the view that it is largely a mystery even to those who practice it. One attractive thing about dermatology is its nomenclature which is large and, for the most part, euphonious. Erythrema, iris tenca, versicolor, make one think of gardens rather than something that makes you scratch. Skin diseases, even when you have them by the right name, are notorious for their obstinate refusal to be cured. The patient must very often wait until his affliction has run its course hoping in the meanwhile that the life of the disease will not be synchronous with the life of the patient.

Even skin diseases, however, can sometimes be cured, even to the point of extinction. Leprosy, which was so very common in biblical times, now is correspondingly rare. We no longer hear about phthyriasis, which must have been quite a scourge at one time. In case you do not recognize it, let me remind you that it was the punishment sent upon Herod "an angel of the Lord smote him and he was eaten of worms and gave up the ghost." Eaten up of worms seems on the surface to be a gruesome exaggeration but Sulla, the Dictator, died of the same thing (too

bad that Hitler, the dictator, is likely to escape it). Here is what Plutarch has to say about Sulla, "The corrupt flesh broke out into lice. Many were employed day and night destroying them but the work so multiplied under their hands that not only his clothes, baths, basins but even his meat was polluted, with that flux and contagion they came swarming out in such numbers. He went frequently into the bath to scour and cleanse his body but in vain; the evil generated too rapidly." Quite a large number of important people died in the same way, their death-bed agonies being carefully recorded. Among the last of the victims to die was Philip the Second of Spain, whose death, by the way, occurred on the 13th of September, 1598. Early in July racking pains in his joints drove Philip to bed. Soon there appeared ulcerous, festering sores that poured out lice in unbelievably huge numbers. This ruler of half the world, master of the wealth of the Indies, whose slightest wish was law to millions, lay rotting and stinking whilst a growing uncontrollable mass of worms slowly ate him to death. The cell, which was his bed-chamber, was avoided by all save those who were compelled to wait on him. For fifty-three days his hideous and prolific sores were hidden under garments that remained unchanged and which formed his shroud as he was taken to the jasper Charnel-House at the Escorial. J.C.H.

A Letter From The President

To the members of the Winnipeg Medical Society:

In electing me to the Presidency of this Society you have bestowed upon me the greatest honor in your power to give. I accept this honor with pride and with a full realization of the trust you have placed in me.

I want this session of the Society to be a successful one and so do you. Together we can make it so. Our Society must be as close to 100% as possible. At present, out of a possible 301, there are 263 members. There are five who have not paid their dues for 2 years and who, according to the constitution, are suspended. I would like every one of those five to get back into the fold. You need us: we need you.

The future holds in it much uncertainty. We cannot afford to fight among ourselves over minor matters. We must have before us the good of the many instead of selfish ideals. We must support and encourage our leaders. And so I would like you to think about your Society's affairs. Get behind the Executive. Be present at every meeting. Say what you think honestly when your opinion is requested. Let us settle our differences quietly amongst ourselves and show others a united and harmonious front.

As president I would extend a most cordial welcome to every medical man in uniform in this district. Easterners or Westerners, it doesn't matter, you, in your way, are serving us, let us, in our way, serve you. You are welcome to attend each and every meeting.

P. H. McNulty.

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Treatment: The recommended method of treatment is as follows:—An initial dose of 50,000 Vitamin D units (1 capsule, "Ostoforte"). This is gradually increased to the effective dose which may be 300,000 or more units daily, depending on the patient's response and tolerance to the medication. When maximum improvement occurs the dose is reduced to a maintenance level which may vary from 100,000-200,000 (2-4 capsules, "Ostoforte") daily. Rest and regulation of the diet. Massage and exercise of the affected parts when indicated. Correction of bowel habits. Removal of foci of infection. Results from this treatment may not be apparent for some weeks, therefore the administration of an analgesic (Acetophen Compound with Codeine, C.T. No. 222 "Frosst") may be indicated in order to promote comfort.

Results: While the results of High Potency Vitamin D therapy are not always dramatic and it may require a number of months of continuous treatment before improvement becomes evident, the fact that we are dealing with frequently intractable and progressive diseases warrants trial of this treatment. The following results have been observed in those cases responding to treatment:—Decrease in pain; Decrease in swelling; Recalcification of osteoporotic bone; Remobilization of joints; and improvement in general health.

We Emphasize: A—No criteria have been established which would enable one to select the cases which will respond favourably to treatment from those which will fail to react. B—No physiological basis exists for the employment of this therapy. It is at present entirely empirical.

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Personal Notes and Social News

Dr. Robert Gibson Greer, son of Mr. and Mrs. Gibson Greer of Winnipeg, is engaged to marry Dorothy Mary, only daughter of Dr. and Mrs. R. C. E. Magee of Winnipeg. The wedding to take place on September 23rd, 1944.

Dr. and Mrs. A. G. Meindl celebrated their thirty-fourth wedding anniversary on August 18th, 1944.

Dr. and Mrs. Everett J. Washington's daughter, Helen Blanch, was married on Saturday, August 19th, 1944, at St. Andrew's United Church, Winnipeg, to P.O. Alan Herbert Hopkins, R.C.A.F., son of Dr. and Mrs. Herbert Hopkins of Toronto.

Lieut.-Colonel C. H. A. Walton, who recently returned from overseas has re-entered civilian practice and is now associated with the Winnipeg Clinic.

Major Norman L. Elvin has returned to Winnipeg after serving four years overseas with No. 5 Canadian General Hospital in Britain, Sicily and Italy. Dr. Elvin will resume civilian practice in the near future at 314 Medical Arts Building.

Surg.-Lieutenant Donald M. Whitley has returned from overseas duty and is now posted at H.M.C.S. Chippewa.

Dr. and Mrs. A. A. Alford's second son, Andrew Allan, was married July 14th, 1944, in Knox United Church, Oakville, Man., to Audrey Doreen, eldest daughter of Mr. and Mrs. John Sheritt of Elm River, Man.

The sympathy of the Executive and members is extended to Dr. Morley S. Lougheed on the recent death of his father, Dr. Thos. Lougheed of Vancouver, B.C., who passed away August 4th, 1944, while visiting in Winnipeg.

Dr. and Mrs. G. P. Armstrong of Portage la Prairie, Man., have been advised that their only son, Flt.-Sgt. G. P. Armstrong, is officially presumed dead. We trust that the near future will bring good tidings countermanding this notification.

Surg.-Lieutenant James G. Fyfe, reported missing in April when H.M.C.S. Athabaskan was sunk, is now in hospital in England, according to word received by his wife, Mrs. Jean Fyfe. Wounded during the engagement when his ship was sunk, Surg.-Lieutenant Fyfe ended up in a hospital in France, but was recently exchanged and sent to England.

The Executive and Members of this Association wish to express their deepest sympathy to Dr. R. F. Rorke on the loss of his wife, who recently died while on a vacation in Eastern Canada.

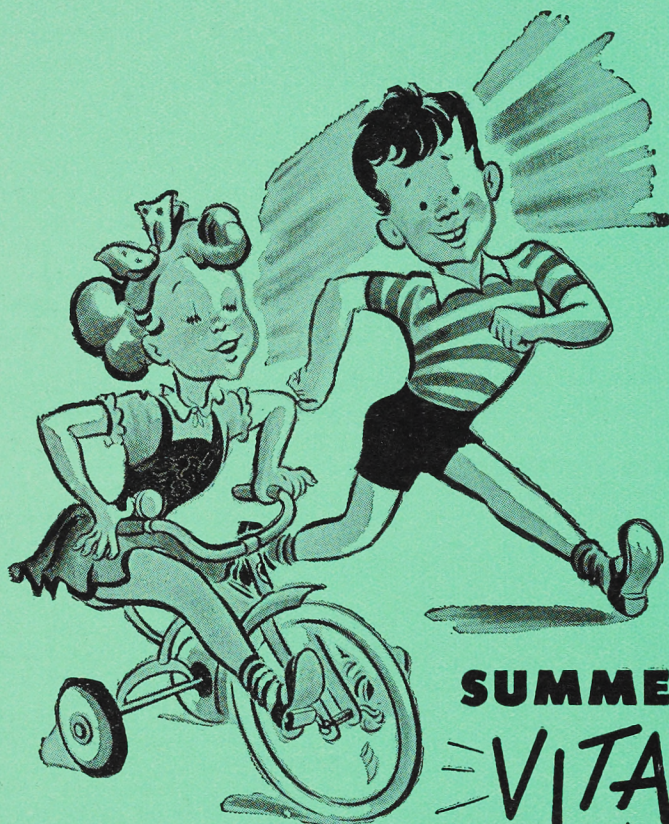
What is a Perennial?

The Oxford dictionary informs us that a perennial is something that comes around regularly each year. Our version of a Perennial is Dr. Digby Wheeler and what a botanical perennial he has become. For many years in succession his beautiful home garden has been awarded the Bank of Commerce trophy for grounds of sixty-six-foot frontage or over. This year Dr. Wheeler won additional laurels when he was awarded the Shaughnessy trophy for the championship garden in Greater Winnipeg.

The Creation of Social Diseases

There are strange things found in the world all 'round
By the men who moil for germs;
When I scan their dope through a microscope
They're as plain as pachyderms.
But the "dark field" light shows a strange, strange sight
That dwarfs the starlit skies;
For there you'll meet the Spirochaete
With world-wide enterprise.
Now Sam McGee was from Tennessee
Where the cotton blooms and grows:
But the Spirochaete is on every street,
Just where—God only knows.
He has a style that is versatile
Putting other germs to shame;
If you think I'm wrong in this doleful song
Step out with some "crimson" dame.
For the aftermath of the crimson path
Is strewn with souls astute
In a million things, except what clings
To a nip of "forbidden fruit";
And ghastly worse is the tragic curse
Of the trusting wife or man
Who finds they're bound to a faithless hound
Of a sexual charlatan.
Though the Spirochaete is the germ elite
Which science can't unlock;
Meet his pal—a spy—who is sneaky, sly
Hats off to the Gonococ!!
In the realm of bugs this pair of thugs
Is the world's most vicious faction;
For they ply their trade with a man and maid
In the guise of sex-attraction.
In Grandma's days her pious ways
Made V.D. talk forbidden;
But a nation's wealth is its members' health;
That fact must not be hidden,
'Cause the havoc wrought 'mong the folk—untaught
And millions more deemed wiser
Has brought more grief than the Axis Chief
And that damned old "Bill"—The Kaiser.
So still worse war is at our door
Than the two "World Wars"—so massive;
Will you make a start?—take an active part
Or park on your "fanny"—passive.
For the Gallup Poll of the V.D. toll
Shows figures yearly higher;
Will you man a gun till the fight is won
Or swear that truth's a liar?

W. J. Sharman, M.D.



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AYERST COD LIVER OIL

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AYERST COD LIVER OILS

Biologically tested and standardized • Bottles of 4 and 16 ounces

AYERST, McKENNA & HARRISON LIMITED

Biological and Pharmaceutical Chemists

Montreal, Canada

Department of Health and Public Welfare

Comparisons Communicable Diseases—Manitoba

(Whites Only)

DISEASES	1944		1943		TOTALS	
	June 18 to July 15	May 21 to June 17	June 20 to July 17	May 23 to June 19	Jan. 1 to July 15, '44	Jan. 1 to July 17, '43
Anterior Poliomyelitis	2	2	3	4	5	15
Chickenpox	142	182	90	165	1524	1078
Diphtheria	19	25	11	16	96	166
Diphtheria Carriers	1	3	---	4	17	17
Dysentery—Amoebic	---	---	---	4	---	6
Dysentery—Bacillary	2	1	1	---	4	7
Erysipelas	4	1	7	8	46	44
Encephalitis	1	---	1	---	4	5
Influenza	---	6	7	30	140	368
Measles	320	796	375	446	4920	2305
Measles—German	8	20	21	61	232	164
Meningococcal Meningitis	---	2	2	2	13	23
Mumps	41	82	174	323	1416	3007
Ophthalmia Neonatorum	---	---	---	---	---	---
Pneumonia—Lobar	3	7	9	11	108	119
Puerperal Fever	---	---	---	---	4	1
Scarlet Fever	85	160	105	188	1602	914
Septic Sore Throat	---	2	3	7	19	30
Smallpox	---	---	---	---	---	---
Tetanus	---	---	1	---	1	1
Trachoma	---	---	---	---	---	2
Tuberculosis	51	80	58	40	341	343
Typhoid Fever	---	---	1	4	12	18
Typhoid Paratyphoid	---	---	3	---	---	3
Typhoid Carriers	1	---	---	---	1	1
Undulant Fever	---	1	3	---	2	6
Whooping Cough	17	40	108	151	189	1391
Gonorrhoea	111	132	115	140	924	1002
Syphilis	53	52	44	57	349	311
Actinomycosis	---	---	---	---	2	1
Meningococcal Meningitis Carriers	---	---	---	---	---	6

DISEASES	1944		1943		TOTALS	
	July 16 to Aug. 12	June 18 to July 15	July 18 to Aug. 14	June 20 to July 17	Jan. 1 to Aug. 12, '44	Jan. 1 to Aug. 14, '43
Anterior Poliomyelitis	12	2	1	3	17	16
Chickenpox	46	147	45	90	1279	1123
Diphtheria	17	20	12	11	114	178
Diphtheria Carriers	1	1	---	---	18	18
Dysentery—Amoebic	---	---	---	---	---	6
Dysentery—Bacillary	---	2	3	1	5	10
Erysipelas	1	4	2	7	58	46
Encephalitis	1	1	---	1	6	5
Influenza	1	2	6	7	148	374
Measles	76	322	155	375	5052	2460
Measles—German	1	8	4	21	233	168
Meningococcal Meningitis	---	---	4	2	14	27
Mumps	18	41	80	174	1434	3087
Ophthalmia Neonatorum	---	---	---	---	---	---
Pneumonia—Lobar	---	6	10	9	117	129
Puerperal Fever	---	---	---	---	4	1
Scarlet Fever	53	87	44	105	1758	958
Septic Sore Throat	---	---	4	3	21	34
Smallpox	---	---	---	---	---	---
Tetanus	---	---	---	1	1	1
Trachoma	---	---	---	---	---	3
Tuberculosis	55	49	30	58	393	373
Typhoid Fever	---	---	---	1	12	18
Typhoid Paratyphoid	---	---	---	3	---	3
Typhoid Carriers	---	1	---	---	1	1
Undulant Fever	1	---	2	3	3	8
Whooping Cough	35	20	79	108	229	1469
Gonorrhoea	149	111	121	115	1073	1051
Syphilis	62	53	32	44	411	331
Actinomycosis	---	---	---	---	2	1
Meningitis Carriers	---	---	---	---	---	6

DISEASE	*738,000 Manitoba	*3,825,000 Ontario	*906,000 Saskatchewan	*2,972,300 Minnesota	*641,935 North Dakota		*738,000 Manitoba	*3,825,000 Ontario	*906,000 Saskatchewan	Minnesota *2,972,300	*641,935 North Dakota
*Approximate Populations.											
Anterior Poliomyelitis	2	12	---	12	2	Anterior Poliomyelitis	12	23	3	49	5
Chickenpox	142	879	72	---	---	Chickenpox	46	190	39	---	---
Diphtheria	19	2	1	19	5	Diphtheria	17	---	1	10	3
Diphtheria Carriers	1	---	---	---	---	Diphtheria Carriers	1	---	---	---	---
Dysentery—Amoebic	---	---	---	11	---	Dysentery—Amoebic	---	---	---	12	---
Bacillary	2	---	---	---	---	Bacillary	---	---	---	---	2
Encephalitis Epidemica	1	---	---	---	4	Encephalitis Epidemica	1	---	1	1	8
Erysipelas	4	7	---	---	2	Erysipelas	1	2	1	---	1
German Measles	8	160	64	---	---	German Measles	1	34	15	---	---
Influenza	---	25	1	---	7	Influenza	1	21	8	---	13
Malaria	---	---	---	4	---	Measles	76	246	70	67	4
Measles	320	1007	188	308	22	Meningococcal Meningitis	---	10	3	12	2
Meningococcal Meningitis	---	7	---	10	4	Mumps	18	109	20	---	---
Mumps	41	392	38	---	---	Ophthalmia Neonatorum	---	---	---	---	---
Ophthalmia Neonatorum	---	---	---	---	---	Puerperal Fever	---	---	---	---	---
Puerperal Fever	---	---	---	---	---	Scarlet Fever	53	131	18	91	10
Scarlet Fever	85	366	41	151	28	Septic Sore Throat	---	7	---	---	---
Septic Sore Throat	---	15	---	---	---	Smallpox	---	---	---	---	2
Smallpox	---	---	---	---	3	Trachoma	---	---	5	---	18
Trachoma	---	---	---	---	---	Tetanus	---	---	---	---	1
Tuberculosis	51	220	18	---	27	Tuberculosis	55	149	---	2	18
Tularemia	---	---	---	2	1	Tuleremia	---	---	---	2	---
Typhoid Fever	---	4	---	1	1	Typhoid Fever	---	14	1	1	1
Typhoid Fever Carriers	1	---	---	---	---	Typhoid Para-typhoid	---	2	1	2	---
Typhoid Para-typhoid	---	1	1	---	---	Undulant Fever	1	1	---	20	2
Undulant Fever	---	3	---	24	1	Whooping Cough	35	112	18	129	99
Whooping Cough	17	110	20	63	48	Gonorrhoea	149	309	---	---	37
Gonorrhoea	111	327	---	---	23	Syphilis	62	209	---	---	20
Syphilis	53	172	---	---	26	† Cases reported for three-week period only as report for the week ending August 12th not received in time to incorporate in this table.					

DEATHS FROM COMMUNICABLE DISEASES

June, 1944

URBAN—Cancer 48, Syphilis 7, Tuberculosis 6, Pneumonia (other forms) 2, Cerebrospinal meningitis 2, Diphtheria 1, Measles 1, Disease of skin 1, Septicemia 1. Other deaths under 1 year 13. Other deaths over 1 year 168. Stillbirths 11. Total 261.

RURAL—Cancer 30, Tuberculosis 14, Pneumonia (other forms) 8, Pneumonia Lobar 5, Whooping

Cough 4, Diphtheria 2, Influenza 2, Dysentery 2, Septic Sore Throat 2, Syphilis 1, Chickenpox 1. Other deaths under 1 year 17. Other deaths over 1 year 203. Stillbirths 16. Total 307.

INDIANS—Tuberculosis 12, Pneumonia (other forms) 5, Scarlet Fever 2, Influenza 1, Measles 1, Pneumonia Lobar 1*, Poliomyelitis 1, Syphilis 1, Whooping Cough 1*. Other deaths under 1 year 2*. Other deaths over 1 year 8*. Stillbirths 0. Total 35*.

*4 whites on Indian Reserves.

★ ★ ★

Pertussis Vaccine

In the April, 1943, issue of the Manitoba Medical Review it was announced that pertussis vaccine, alone and combined with diphtheria toxoid, has been added to the list of biologics distributed free of cost to physicians in the Province of Manitoba by the Department of Health and Public Welfare.

As there had been considerable argument regarding the value of pertussis vaccine as a

prophylactic against the disease it was especially requested that nominal records be kept and copies sent to the Department of all individuals receiving pertussis vaccine or the combined antigen. These records, covering several years, may be of considerable value in estimating the efficacy of pertussis vaccine.

A year has passed and we may take a look at the records. The table below shows a summary of the immunizations done for which we have received records.

IMMUNIZATIONS AGAINST WHOOPING COUGH — MANITOBA — APRIL 1 to DECEMBER 31, 1943

Age Groups	Complete Immunizations							Augmenting Courses			
	Under 7 Mos.	7-11 Mos.	1 Yr.	2-5 Yrs.	6 Yrs. and ove	No Age given	Total	2-5 Yrs.	6 Yrs. and ove	No Age given	Total
Pertussis Vaccine	82	208	210	632	448	852	2432	3	30	3	45
Combined Pertussis Vaccine and Diphtheria Toxoid	103	267	537	1029	422	297	2655	12	10	0	22
TOTALS	185	475	747	1661	870	1149	5087	15	40	3	67

We also have records of 643 children given one dose only and 704 given two doses only. The Connaught Laboratories recommend that each child receive SIX CC'S of vaccine whether it be given in three, four or five doses and that the interval between doses be NOT LESS than three weeks. It is quite apparent that these one and two doses represent largely wasted material and very little or no protection to the children.

From April first to December thirty-first, 1943, we distributed pertussis vaccine sufficient to give 6 cc.'s to 4,928 children, and combined antigen sufficient to give 6 cc.'s to 6,716 children.

Records received to date (April 1st, 1944) do not cover one half this material. This does not mean that one half was wasted but does mean that in many cases records were not kept or were not sent in to the Department.

These two products are expensive and cost the Province almost seven thousand dollars in 1943. Therefore, we would urge most strongly that in 1944 and coming years, records be kept of everyone being treated with these materials and copies sent to the Department, that as little as possible be wasted and that every effort be made to give SIX CC.'S to every child who starts treatment.

Looking at the table we find that LEAST immunization was done under two years in the

age group where it would have been of most benefit. How about reversing that this year? The group of "no age given" simply means poor recording and the physicians gave an estimate of the number done.

Deaths from whooping cough occur almost entirely in the age group under two years and mainly under one year. If we are to save lives pertussis vaccine should be given at the age of six months or even at four months (in smaller than 2 cc. but repeated doses to equal 6 cc.) On account of the cost of these two biologics and as the dangerous age from whooping cough as a cause of death is past, we do not recommend their use in children of school age or older.

It is recommended that an AUGMENTING or reinforcing dose of 1 cc. of pertussis vaccine be administered subcutaneously both TWELVE MONTHS and THIRTY MONTHS after each initial course of three or four doses.

Whooping cough is a serious disease. In Manitoba in 1943, 1,894 cases were reported (55 of them in Treaty Indians) and 57 deaths (18 of them in Treaty Indians). There is little doubt that some of these might have been saved by EARLY immunization. Be sure to keep records of those done! In reporting cases of whooping cough state whether they have been immunized and, if so, the number of doses and when.

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(Canadian Medical Association Journal, June, '44, pp 562)

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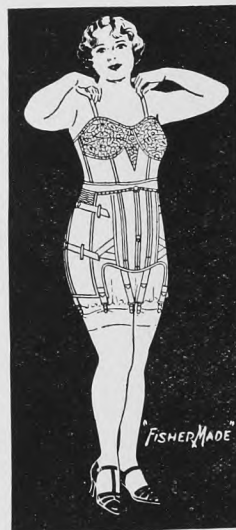
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